Kimberly Wallace LPC, LLC
2852 Johnson Ferry Road Suite 101, Marietta, GA 30062
PHONE: 404-906-9831 WEBSITE: www.kimberlywallacelpc.com

CONFIDENTIAL CLIENT INFORMATION FORM

Today's date: _____

Client name: _____ Date of birth: _____
Last First Middle

Parent/Guardian name: _____ Date of birth: _____
Last First Middle

Home street address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

Email: _____

Appointment information may be communicated to me via □ text □ cell phone □ email □ home phone

In case of life or death emergency you have my permission to contact: _____

Cell Phone: _____ Signature: _____

What prompted you to seek treatment at this time? (What are your goals at this time?)

_____

_____

Have you received treatment for this issue before? □ yes □ no
If yes, please indicate the type of treatment and how many providers you have seen:

Name Dates Reason

□ Psychiatrist _____

□ Neurologist _____

□ Cardiologist _____

□ Alternative/Holistic/Naturopathic (include type) _____

□Therapy (include type) _____

□ Psychiatric Inpatient Hospitalization (if multiple include dates) _____

_____

□ Outpatient Treatment Program (if multiple include dates) _____

_____

□ Other: _____

Please list any prior diagnoses: _____

_____

Were you referred to me by a medical professional or therapist? □ yes □ no

Name and phone number of referring clinician _____

Do I have your permission to thank them for their referral? □ yes □ no

Do you want me to communicate with them about your treatment? □ yes □ no

How did you find me? □ Internet search □ Psychology Today □ Insurance Panel □ Friend/family

YOUR READINESS AND MOTIVATION FOR CHANGE

Please rate your willingness to improve your health on a scale of 1 (not willing) to 5 (very willing).

Take medications/supplements as prescribed by your medical doctor	1	2	3	4	5
Adjust or modify your diet	1	2	3	4	5
Engage in regular exercise/physical activity	1	2	3	4	5
Modify your lifestyle (i.e. work demands, sleep habits, exercise)	1	2	3	4	5
Visit your primary physician or other medical specialists	1	2	3	4	5
Participate in additional therapies/treatment	1	2	3	4	5
Practice stress reducing/relaxation exercises	1	2	3	4	5
Journal/Writing exercises	1	2	3	4	5

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

MEDICAL HISTORY

Rate your current physical health: □ Excellent □ Good □ Average □ Declining □ Poor

Height _____ Weight (if applicable) _____ Age_____ Gender _____

Please list any significant medical problems, illnesses, injuries or disabilities (past or present – including problems at birth) I should know about: _____

_____

_____

_____

_____

Primary Care Physician/Clinic: _____

Address: _____ Phone: _____

May I contact your medical doctor so we can coordinate treatment? YES NO

Have you had a head injury or any of the following:

□ Seizure/seizure like activity □ Periods of fogginess or confusion □ Concussion

□ Whiplash □ Loss of consciousness (describe): _____

□ Head trauma (describe, list date or approximate age): _____

□ Stitches on face or head (describe): _____

Current Medications:

Name of Medication Dosage Purpose Name of Prescribing Doctor

_____

_____

_____

_____

_____

_____

What type of physical exercise do you engage in? _____ Days per week? ____

Do you restrict your eating in any way? How and Why? _____

_____

For Women Only: (men skip to "Substance Use")

At what age did you start to menstruate (get your period)? _____

How regular are your periods? _____ How long do they last? _____ Heavy ____ Light _____

How much pain do you have? _____ Other experiences during period: _____

PMS experiences: _____

If your menopause has started, at what age did it start? _____ What menopausal signs or symptoms have you experienced? _____

Have you had a hysterectomy? □ yes □ no If yes, at what age? _____

Are you taking Hormone Replacement Therapy? □ yes □ no Type: _____

Please list all of your pregnancies and what happened with these pregnancies (your age, type of birth, miscarriage, abortion, any problems):_____

_____

SUBSTANCE USE

Do you smoke or use tobacco? YES NO If YES, how much per day?_____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO (1 standard drink is .6 oz of alcohol)

How many times in the past 12 months have you had 3 or more drinks in one sitting?

____ 25 times or more ____ 13-24 times ____ 6-12 times ____ 1-5 times ____None

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

FAMILY

Did you grow up with someone who was a problem drinker, alcoholic or used street drugs? □ yes □ no

Did anyone in your family have a mental illness or attempt/commit suicide? □ yes □ no

Did anyone in your family go to prison? □ yes □ no If yes, who? _____

How would you describe your relationship with your mother? __

_____

How would you describe your relationship with your father?_____

_____

Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

_____

How many sisters do you have? _____ Ages? _____

How many brothers do you have? _____ Ages? _____

How would you describe your relationships with your siblings? _____

_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE

Marital Status: □ Single □ Engaged □ Married □ Separated □ Divorced □Widowed

Name of Spouse: _____ Age: _____ How long married? _____

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Children

	Name	Age	Gender	Grade	Health
1.					
2.					
3.					
4.					

Previously Married/Life Partnered? □ yes □ no

If yes, length of previous marriages/committed partnerships_____

Describe any problems any of your children are having: _____

_____

List the names and ages of others living in your household: _____

_____

Have you ever been sexually abused? □ yes □ no If yes, who? _____

Have you ever been physically abused? □ yes □ no If yes, who? _____

Have you ever been verbally abused? □ yes □ no If yes, who? _____

Have you ever witnessed or been involved in domestic violence? □ yes □ no

POOR EXCELLENT

Current level of satisfaction with your friends and social support: 1 2 3 4 5 6 7

Please briefly describe your coping mechanisms and self-care:_____

_____

_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree (or Higher) ___ Vocational Degree___

What is your current employment? _____

POOR EXCELLENT

Employment Satisfaction: 1 2 3 4 5 6 7

Any past career positions that you feel are relevant? _____

_____

SPIRITUAL LIFE

I consider myself: □ Christian □ Jewish □Buddhist □Muslim □Hindu

□ Agnostic □ Atheist □ Unknown □ Other: _____

I am happy with my current spiritual journey. □ yes □ no Why? _____

I am active in the practice of my faith. □ yes □ no Why? _____

I am visiting a counselor who advertises Christian Counseling because: (Circle the number of all that apply)

1) I hope to get counseling from a Christian/Biblical perspective;
2) I am open to hearing a Christian/Biblical perspective on my issues;
3) I was referred here by a friend who was helped and hope to have the same good result;
4) You offer Christian/Biblical based counseling? What does that mean?

How much do you want spirituality included in your treatment?

□ None □ Some □ Neutral □ A lot □ All about spirituality

Please check any symptoms you are currently experiencing and approximate number of days per week you are experiencing these symptoms:

□ Appetite Increase	0 1 2 3 4 5 6 7	□ Excessive worry	0 1 2 3 4 5 6 7
□ Appetite Decrease	0 1 2 3 4 5 6 7	□ Anxiety	0 1 2 3 4 5 6 7
□ Weight gain (unintentional)	0 1 2 3 4 5 6 7	□ Fear	0 1 2 3 4 5 6 7
□ Weight loss (unintentional)	0 1 2 3 4 5 6 7	□ Hopelessness	0 1 2 3 4 5 6 7
□ Difficulty Concentrating	0 1 2 3 4 5 6 7	□ Panic	0 1 2 3 4 5 6 7
□ Sleep Difficulties □ falling asleep □ staying asleep □ waking early	0 1 2 3 4 5 6 7	□ Intrusive thoughts	0 1 2 3 4 5 6 7
□ Sleep too much	0 1 2 3 4 5 6 7	□ Racing thoughts	0 1 2 3 4 5 6 7
□ Nightmares	0 1 2 3 4 5 6 7	□ Feeling Overwhelmed	0 1 2 3 4 5 6 7
□ Low Motivation	0 1 2 3 4 5 6 7	□ Suicidal Thoughts	0 1 2 3 4 5 6 7
□ Isolation from Others	0 1 2 3 4 5 6 7	Have you ever attempted suicide □ yes □ no	
□ Fatigue or low energy	0 1 2 3 4 5 6 7	If yes, when? _____	
□ Irritability	0 1 2 3 4 5 6 7	were you hospitalized? □ yes □ no	
□ Low self-esteem	0 1 2 3 4 5 6 7	□ Desire to hurt anyone	0 1 2 3 4 5 6 7
□ Depressed mood	0 1 2 3 4 5 6 7	□ Self-harm (cutting, etc.)	0 1 2 3 4 5 6 7
□ Tearful or crying spells	0 1 2 3 4 5 6 7	□ Bingeing/Purging	0 1 2 3 4 5 6 7
□ Excessive Shopping	0 1 2 3 4 5 6 7	□ Loneliness	0 1 2 3 4 5 6 7
□ Procrastination	0 1 2 3 4 5 6 7	□ Low Sex Drive	0 1 2 3 4 5 6 7
□ Memory Concerns	0 1 2 3 4 5 6 7	□ High Sex Drive	0 1 2 3 4 5 6 7

Are there any other symptoms you are experiencing that are not listed? Please provide.

_____

_____

_____

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INFORMATION, AUTHORIZATION AND CONSENT FOR PSYCHOTHERAPY

General Information
The therapeutic relationship is both highly personal and at the same time, a contractual agreement. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies and several other details regarding your treatment. Your relationship with me is a collaborative one, and I am open to questions, comments, or suggestions regarding your process of therapy at any time.

The Therapeutic Process
You are exercising courage and taking a positive step to seek therapy. Your treatment results depend on your willingness to engage in this process that may at times result in considerable discomfort. Reflecting on difficult events and increasing your awareness of emotions attached to events can bring strong feelings of anxiety, depression, anger, etc. as well as physical sensations in your body. There is no one miracle pill, technique or cure. I cannot promise that your situation or behaviors will change. I can promise that as you engage in the process to listen, attune, support and seek to understand you, the connections within your process, and assist you in clarifying your goals for yourself.

Confidentiality
I will keep everything you say within session and any materials related to session confidential with the following limitations or exceptions:

(1) You direct me to tell someone else and you sign a "Release of Information" form;
(2) I determine that you are a danger to yourself or to others;
(3) You report information about the abuse of a child under age 18, an elderly person over age 65, or a disabled individual who may require protection;
(4) I am ordered by a judge to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. The state of Georgia has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say confidential.

Please note that in couple's counseling, I do not agree to keep secrets. Information revealed in any context may be discussed with either partner. If you have questions about confidentiality, I will be happy to discuss your concerns with you.

In Case of Emergency
I provide counseling considered as outpatient services, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am always I available. If at any time this does not feel like enough support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, I will return phone calls within 24-48 hours. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225
- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.454.5589
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911.
- Go to the emergency room of your choice.

Please initial you have read this page _____

Professional Relationship, Ethics, Client Well-fare and Safety
Our relationship must be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other way, we would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. To offer all clients the best care, my judgment needs to be unselfish and purely focused on your needs. Therefore, your relationship with me must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients confidential. For your confidentiality, I will not address you in public unless you speak to me first. I must also graciously decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my ethical duty as a therapist to always maintain a professional role in the event you need to return to work through another issue. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Minors

Parent Authorization for Minor's Mental Health Treatment
I also work with adolescents from age 13 – 18, who are under care of their parents or legal guardians. To authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Me
During my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, always, my patient is your child – not the parents/guardians nor any siblings or other family members of the child.

Please initial you have read this page _____

If I meet with you or other family members during your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Confidentiality of Minor Clients

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police].
- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

Example: If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If you child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.

Example: If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Please initial you have read this page _____

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents
Although the laws of [this State] may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation
When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $200 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Adolescent Patient:
By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature _____ Date_____

Parent/Guardian of Minor Patient:
Please initial each line and sign below, indicating your agreement to respect your child's privacy:

_____ I will refrain from requesting detailed information about individual therapy sessions with my child.
_____ I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.
_____ Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment.
_____ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above.

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

Please initial you have read this page _____

About Kimberly
I am a Licensed Professional Counselor in the State of Georgia (LPC#008384). I earned a Bachelor of Science degree from Georgia Southern University in 1990 and a Master of Arts in Counseling from Liberty University in 2012.

I am trained in Strategic Trauma and Abuse Recovery (STAR©), Sand Tray Therapy, Certified in Brainspotting and use a variety of tools, techniques and resources to engage with clients to increase freedom, health and wholeness mentally, emotionally, physically and spiritually.

PRACTICE POLICIES

Payment and Cost of Sessions
The fee for my initial 60-minute counseling assessment is $150. The fee for follow-up sessions is $150 for 50-55-minute sessions, $120 for 45-minute sessions or $200 for 90 minute sessions.

If you choose to use a credit card with me, it will be stored in an electronic, HIPPA compliant practice management system, Simple Practice, which has signed a BAA with me. This is for your convenience to cover session fees and practice management fees. You will always be informed of any charges to your account. **You may opt out of having your credit card stored by initialing here _____ or by paying with cash or checks.**

Doing psychotherapy by telephone is not ideal and needing to talk to me between sessions may indicate that you need extra support. If this is the case, you and I will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed 20 minutes in duration will be billed at full session fee.

Private Pay: The fee for each session will be due at the beginning of the session. I accept cash, personal checks, or credit cards as forms of payment. Please note that there is a $30 fee for any returned checks. If you are unable to pay for your appointment, the full balance will be due prior to your next session.

Insurance: I am currently not "in-network" with insurance companies at this location. If you plan to use your insurance to cover the cost of counseling, please call your insurance company to verify your behavioral health benefits and to find out the limitations of your plan. Please be aware that most insurance companies will not pay for sessions that are not considered "medical necessity." In other words, if your goal is personal growth and development, they will not pay. Each insurance plan has specific specifications regarding payment for services.

You may be reimbursed for your services by submitting claims to your insurance company. You will need to check with your insurance company to verify your eligibility. It is your responsibility to pay the full session fee. I will provide you with an invoice that you can submit to your insurance company for partial reimbursement.

Cancellation Policy
In the event you are unable to keep your appointment, you must notify me at least 48 hours in advance. You will be charged the full session fee for missed sessions or those cancelled without 48-hour notice, except in cases of sudden illness, transportation breakdown, or family emergency.

Ending Therapy
You have the right to end therapy whenever you choose. If you do decide to exercise this option, I encourage you to talk with me about the reason for your decision, both for my own feedback as well as to discuss your progress and further recommendations or referrals. Likewise, at my discretion, I reserve the right to end our therapy work together and provide you with some appropriate referrals, for reasons including, but not limited to, failure to participate in therapy, conflicts of interest, untimely payment of fees, or my belief that I may not be the best person for your needs.

Please initial you have read this page _____

Use of Technology
It is of utmost importance to me that I maintain your confidentiality, respect your boundaries, and ascertain that your relationship with me remains therapeutic and professional.

Cell phones: It is important for you to know that cell phones may not be completely secure or confidential. However, this is the most common way that I communicate with clients, and they communicate with me. If this is a problem, please feel free to discuss this with me.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. I realize that many people prefer to text and/or email because it is a quick way to convey information. My phone and e-mail are password protected and secure to the best of my ability. *I prefer to limit these types of communications to appointment confirmations, rescheduling or cancellations only.* Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. If you do, please know that I will not respond. *You also need to know that I am required to keep a summary or copy of all emails and texts as part of your clinical record that address anything related to therapy.* My e-mail kimberly@kimberlywallacelpc.com is encrypted through a Business Associate Agreement (BAA) with GoDaddy and Microsoft Corporation. The BAA means that the company is willing to attest to HIPAA compliance and assume responsibility for keeping your PHI secure.

Social Media: It is my policy not to accept requests from any current or former clients on social networking sites such as Facebook, LinkedIn, Twitter, etc. because it may compromise your confidentiality. Please refrain from contacting me using social media messaging systems such as Facebook Messenger. These methods have insufficient security, and I do not watch them closely. I would not want to miss an important message from you.

Search Engines: It is my policy not to search for my clients on Google or any other search engine. I respect your privacy and make it a policy to allow you to share information about yourself with me as you feel appropriate. If there is content on the Internet that you would like to share with me for therapeutic reasons, please print this material and bring it to your session.

Location-Based Services: If you use location-based services on your cell phone, you may compromise your privacy while attending session at my office. My office is not a check-in location on various sites such as Foursquare, however it can be found as a Google location. Enabled GPS tracking makes it possible for others to surmise you are a counseling client due to regular check-ins at my office location. You may want to turn off your location services for privacy when attend sessions at my office.

Blogs: I may post counseling information or therapeutic content on my professional blog. If you have an interest in following my blog, you are welcome to. However, please do so only if you are comfortable with the public knowing your name is attached to Kimberly Wallace LPC LLC.

Recommendations to Websites or Applications (Apps):
During your treatment, I may recommend that you visit certain websites for pertinent information or self-help. I may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide and communicate to me if you would like this information as adjunct to your treatment or if you prefer that I do not make these recommendations.

Please initial you have read this page _____

Website Portal and Secure Messaging
I have a client portal that is accessible through my website at https://kimberlywallacelpcllc.clientsecure.me, powered by Simple Practice. Simple Practice ensures this portal is encrypted to the federal standard, HIPAA compatible, and has agreed to sign a HIPAA Business Associate Agreement (BAA). The BAA means that Simple Practice is willing to attest to HIPAA compliance and assumes responsibility for keeping our interactions secure and your PHI confidential. If you choose to utilize this service, I will provide detailed directions regarding how to log-in securely. I also strongly suggest that you only communicate through a device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Additionally, through the client portal, you have the option of receiving text and/or email reminders of your appointments with me and/or billing information.

In summary, technology is constantly changing, and there are implications to all the above that we may not realize at this time. Please feel free to ask questions and know that I am open to any feelings or thoughts you have about these and other modalities of communication.

Notice of Privacy Practices
I comply with HIPAA laws in protecting your private health information. The full notice of privacy practices is available on my website: www.kimberlywallacelpc.com/forms.

Our Agreement to Enter into a Therapeutic Relationship
I genuinely look forward to walking on your journey toward freedom, health and wholeness. If you have any questions about any part of this document, please ask.

Please print, date, and sign your name below indicating that:

- You have provided information that is current and true to the best of your knowledge
- You have access to use the Client Portal for secure messages and appointment reminders.
- You have read and understand the contents of this "Information, Authorization and Consent to Treatment" form
- You have read and understand the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices" provided to you on my website www.kimberlywallacelpc.com/forms.
- Your signature also indicates that you agree to the policies of your relationship with me, and you are authorizing me to begin treatment with you.

_____
Client Name (Please Print)

_____ _____
Client Signature **Date**

_____
Parent/Guardian Name (Please Print)

_____ _____
Parent/Guardian Signature **Date**

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____ _____
Therapist's Signature **Date**

Kimberly Wallace LPC, LLC
2852 Johnson Ferry Road Suite 101, Marietta, GA 30062
PHONE: 404-906-9831 WEBSITE: www.kimberlywallacelpc.com

I acknowledge that I have received or have declined to read the Notice of Privacy Policies (HIPAA privacy policies) available on www.kimberlywallacelpc.com/forms. This notice outlines how I can and cannot use your private health information. Please discuss any questions or concerns you may have with me.

_____ _____
Client Signature Date

If Applicable:

_____ _____
Parent's or Legal Guardian's Name (Please Print) Date

_____
Parent's or Legal Guardian's Signature

_____ _____
Parent's or Legal Guardian's Name (Please Print) Date

_____
Parent's or Legal Guardian's Signature